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CLICK HERE FOR THE DIRECTOR OF PUBLIC SOCIAL SERVICES' REPORT DATED JULY 24, 2013 (In response to Board Order 5-D of June 24, 2013)

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CLICK HERE FOR THE CHIEF EXECUTIVE OFFICER'S REPORT DATED OCTOBER 9, 2013 (In response to Board Order 5-G of June 24, 2013)

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CLICK HERE FOR THE CEO'S REPORT ON THE GOLF REVENUE DATED SEPTEMBER 30, 2014

COUNTY OF LOS ANGELES
DEPARTMENT OF AUDITOR-CONTROLLER

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WENDY L. WATANABE
AUDITOR-CONTROLLER

July 16, 2013

TO: Supervisor Mark Ridley-Thomas, Chairman
Supervisor Gloria Molina
Supervisor Zev Yaroslavsky
Supervisor Don Knabe
Supervisor Michael D. Antonovich

FROM: Wendy L. Watanabe
Auditor-Controller

Cynthia D. Banks, Director
Community and Senior Services

SUBJECT: **DEPARTMENT OF COMMUNITY AND SENIOR SERVICES – WORKFORCE INVESTMENT ACT FUNDING (Board Motion No. 5-F, June 24, 2013)**

On June 24, 2013, during the Fiscal Year (FY) 2013-14 Budget Deliberations, your Board identified a budget adjustment request submitted by the Department of Community and Senior Services (CSS) to reallocate $768,000 of its Workforce Investment Act (WIA) funds within CSS' internal budget units. Your Board instructed the A-C and the Director of CSS to report back in 30 days of the following: (1). Whether the $768,000 is additional funding that will be allocated to the Auditor-Controller (A-C) for WIA Program audit enhancement in FY 2013-14; and (2). If the funding is additional to the current level, how this additional fund will be used to improve fiscal and program monitoring of WIA agencies.

Budget Adjustment in CSS' Budget

CSS contracts with the A-C to conduct program and fiscal monitoring of all WIA agencies. In FY 2013-14, there are no additional funds included in the Budget Adjustment for the A-C to provide additional fiscal or program audits of WIA agencies. The reallocation of $768,000 is a technical entry within CSS' budget to transfer appropriation from the Assistance budget to the Administration budget. This entry is needed to accurately align funding levels with expenditures.

A-C's Current Audit Review

There are currently 27 WIA contracts at 24 agencies and the A-C performs annual monitoring reviews of all WIA contract agencies. The purpose of the A-C's annual on-site reviews is to determine whether each WIA contractor provided the services in compliance with their County contract and WIA requirements. Once the review is complete, the A-C discusses the results with CSS and the agency, and a final report with recommendations, and the agency's corrective action plan is issued to the contractor.

Once all reports have been issued, the A-C prepares a summary report to your Board, summarizing all 27 reviews and findings. The A-C also consults with CSS staff to obtain their perspectives on improving the contract monitoring efforts, training needs, monitoring instruments and overall contract monitoring plans.

The State Employment Development Department (EDD) requires CSS to annually monitor all WIA contracts. CSS has complied with this requirement since FY 2004-05 by contracting with the A-C to perform the monitoring. In the past three fiscal years, the A-C has identified approximately $2 million in questioned costs and issued 79 individual reports. Both CSS and the EDD review and approve the A-C's monitoring agreement, which includes a detailed audit program to ensure that the reviews include all requirements and compliance.

On July 11, 2013, the A-C and CSS met with three members of the Workforce Investment Board (WIB) Leadership (Messrs. Jerry Gaines, Richard Dell, and John Adelman) and provided an overview of the WIA Program's monitoring process. It was a positive meeting with a good exchange of information. Based on the discussion, the members requested that a similar presentation to be made to entire WIB. This will be done at the WIB's next quarterly meeting in September 2013. Also, given the WIB's oversight role of the local WIA system, it was agreed that all future monitoring and resolution reports will be shared with the WIB ongoing.

In conclusion, while the Budget Adjustment did not represent an increase in funding for the A-C's monitoring of the WIA Program, the A-C, CSS, and WIB continuously work together to improve the fiscal accountability and enhance the quality of the WIA Program's monitoring.

If there are any questions, please let us know, or your staff may contact Elaine Boyd at (213) 253-0303.

WW:CB:AB:EB

c: William T Fujioka, Chief Executive Officer
Sachi A. Hamai, Executive Officer, Board of Supervisors
Jerry Gaines, WIB Chair
Public Information Office
Audit Committee

County of Los Angeles
DEPARTMENT OF PUBLIC SOCIAL SERVICES
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SHERYL L. SPILLER
Director

July 24, 2013

TO: Each Supervisor

FROM: Sheryl L. Spiller, Director

SUBJECT: MOTION BY SUPERVISOR KNABE ON CALWORKS FUNDING USED FOR SUBSIDIZED EMPLOYMENT (Board Motion #5, JUNE 24, 2013)

On June 24, 2013, during the Fiscal Year (FY) 2013-14 Budget Deliberations, a motion was put forth by Supervisor Don Knabe which was subsequently passed by the Board, for the Director of Public Social Services to report back in 30 days with a plan to take full advantage of the funding available through the CalWORKs program for subsidized employment, including how the program will be implemented to employ as many individuals as possible. This is in response to the motion and provides the Department's plan to fully utilize the increased funding for subsidized employment.

Based on the adopted State Budget for FY 2013-14, it is estimated that the Department may receive an additional $8.4 million to implement and expand its subsidized employment program for CalWORKs adults. In addition, there is an existing $6.0 million available in the subsidized employment program budget for FY 2013-14, thereby bringing the total available funding to $14.4 million with the estimated additional funds.

In order to fully maximize the subsidized employment funds which will provide employment opportunities to CalWORKs participants, we are targeting implementation as soon as the State releases the new requirements, as directed by Assembly Bill 74. The State's new requirements could be released as soon as November 2013.

With the estimated additional State funding, the Department will double the existing 940 subsidized employment slots that are covered under our base budget. This will increase our FY 2013-14 slots from 940 to 1,880 slots. In addition, the South Bay Workforce Investment Board (SBWIB), our current contractor, has verified its employer capacity for the expanded program and its ability to recruit additional employers. The expanded subsidized employment program will include our current model consisting of two program designs, Paid Work Experience (PWE) and On-the-Job-Training (OJT).

Participants identified for the PWE model are placed in government or non-profit agencies with the SBWIB as the employer of record. PWE participants earn $8.00 per hour and work up to 35 hours per week for a period of six months. The County subsidizes 100 percent of the wages.

Participants identified for the OJT model are placed in private-for-profit companies. OJT participants may work up to six months, 40 hours per week and earn at least $8.00 per hour. However, the employer may opt to increase the salary. For the first two months, SBWIB is the employer of record and the County subsidizes 100 percent of the wages. Thereafter, the OJT employer becomes the employer of record and pays the employee wages, Workers' Compensation and payroll taxes, and is reimbursed for a portion of the wages.

We will be seeking Board-delegated authority to amend our existing contract with the SBWIB to increase the maximum contractual funds for our subsidized employment program to accommodate the additional State funding.

If you have any questions, please contact me at (562) 908-8383, or your staff may contact Jose R. Perez, Chief In-Charge, at (562) 908-8633.

SLS:sd

c: Chief Executive Officer
County Counsel
Executive Officer, Board of Supervisors
Deputy Chief Executive Officer

County of Los Angeles
DEPARTMENT OF CHILDREN AND FAMILY SERVICES
425 Shatto Place, Los Angeles, California 90020
(213) 351-5602

PHILIP L. BROWNING
Director

FESIA A. DAVENPORT
Chief Deputy Director

August 9, 2013

To: Supervisor Mark Ridley-Thomas, Chairman
Supervisor Gloria Molina
Supervisor Zev Yaroslavsky
Supervisor Don Knabe
Supervisor Michael D. Antonovich

From: For Philip L. Browning, Director
Department of Children and Family Services

Jonathan E. Fielding, M.D., M.P.H
Director and Health Officer
Department of Public Health

RESPONSE TO THE JUNE 24, 2013 BOARD MOTION (ITEM NO. 5-H) ON PUBLIC HEALTH NURSES

Executive Summary

This is in response to your Board's motion on June 24, 2013, instructing the Department of Children and Family Services (DCFS) and the Department of Public Health (DPH) to provide a report on the nursing programs in regards to the following:

a) A description of the roles and responsibilities of Public Health Nurses (PHNs) working with youths under court jurisdiction and/or DCFS' supervision, including the tasks that these PHNs currently perform;
b) Copies of written policies and procedures that describe when, under what circumstances, and how PHNs are dispatched and should be engaged to serve at-risk youth under DCFS' supervision or Court jurisdiction, including when PHNs conduct in-person visits with a youth;
c) Data on workloads, health outcomes, and number and type of consultations provided, all specified by office or region;
d) Any other dashboard data that the Departments currently collect to monitor and ensure high quality, efficiency, uniformity and productivity, and an adequate distribution of nursing resources countywide; and
e) A description of the training that each Department provides the PHNs, social workers, or other staff, on the functions and responsibilities of the PHNs including copies of training schedules and curriculum.

BACKGROUND

In 1993, the DCFS Public Health Nurse (PHN) Program was established in collaboration with the Department of Health Services (DHS) and the Department of Mental Health (DMH). The nurses were managed through DHS and co-located in the 19 DCFS regional offices. Initially, the program was comprised of 20 PHNs and later increased to 30. On November 9, 1995, the Board approved transferring the administration of the PHN Program from DHS to DCFS to avoid layoffs during the DHS 1995 fiscal crisis. The DCFS nursing program currently includes 74 PHNs.

In 1999, the DPH Health Care Program for Children in Foster Care (HCPCFC) was established when the State appropriated State general funds under section 16501.3 of the Welfare and Institution Code. This legal authority mandates each County to "use the services of a foster care public health nurse" to serve as a liaison with health care professionals and other providers of health-related services to coordinate all essential health care services, and restricts the funding to children detained in out-of-home placement in the foster care system. The DPH HCPCFC currently funds 73 PHNs co-located in the 19 DCFS regional offices.

PHN ROLES AND RESPONSIBILITIES

While the PHNs in the DCFS and DPH programs share similar roles and responsibilities, they serve different populations within the foster care system (see Attachment A). For a detailed description of the roles and responsibilities of each of the programs see Attachment B (DCFS) and Attachment C (DPH). The DCFS PHNs consult with Children's Social Workers (CSWs) regarding the health care and safety needs of children as they enter the foster care system during the investigative phase (Emergency Response), including voluntary family maintenance, family maintenance and voluntary family reunification cases. The DPH PHNs consult with CSWs when children are detained in out-of-home placement, including those children under the jurisdiction of the Probation Department and Edmund D. Edelman's Children's Court. For more detailed information regarding the scope of practice and specific tasks the PHNs perform in the two nursing programs, see Attachment A.

POLICIES AND PROCEDURES

Attachments D (DCFS) and E (DPH) provide the written policies and procedures that describe when, under what circumstances, and how PHNs are dispatched and engaged when serving at-risk youth under DCFS supervision or court jurisdiction, including when in-person visitations are warranted. Both departments have extensive written policies and procedures that provide program standards and operating procedures related to the day-to-day functions and requirements of the programs. DCFS' policies can be accessed through the DCFS policy website at the following link: http://lacdcfs.org/Policy/DCFSPolicy/dcfs_policy.html. A hard copy of the policies and procedures manual that govern the DPH HCPCFC program can be provided upon request.

WORKLOAD AND HEALTH OUTCOMES DATA

Attachment F provides workload data for DCFS and Attachment G provides workload data for DPH, including a breakdown of PHN consultations for the two programs for Fiscal Year (FY) 2012-13. Currently DCFS is collecting workload and consultation data by office and region. DPH is actively working towards capturing workload data by office and region and anticipates having the data available in these formats within the next six (6) months.

Additionally, neither Department is capturing population-based outcome data. While considerable progress has been made towards identifying and capturing relevant outcome data fields, a number of issues still need to be resolved before accurate health outcome data can be reported. For example, a number of data fields in the state's Child Welfare Services/Case Management System (CWS/CMS) are not well defined and the validity of the data being collected in these fields needs to be assessed. As there is currently no formal standardized procedures for how data is entered into the (CWS/CMS) system, DCFS and DPH are working to develop a codebook that will define the specific data codes needed to ensure standardized data entry. It is anticipated that the two departments will address these issues in the near future to allow the reporting of reliable and valid population-based health outcome data that can be used to provide better service delivery and to maximize the use of resources.

Attachment H provides DCFS PHN case scenarios to demonstrate potential health outcomes that may be achieved through the use of PHN nursing expertise.

DASHBOARD DATA

The Departments currently do not collect any dashboard data other than the monthly and annual workload data reports referenced in Attachments F and G above, which are used to guide the distribution of nursing resources countywide within the regional offices. As noted, the Departments are in the process of capturing population-based health data for children in the foster care system. When this data becomes available, it will be possible to distribute nursing resources countywide based on burden of medical need and/or a disproportionate share of medically fragile children in the regional offices.

DEPARTMENTAL TRAINING FOR PHNs

The future plan of the Departments is to combine the current comprehensive DPH and DCFS training curriculums to ensure standardization of training for PHNs in both departments. This will provide the highest quality of service to children and families and enhance positive health outcomes. Attachment I provides a detailed description of trainings currently received by DCFS PHNs and Attachment J for DPH PHNs.

If you have any questions, please feel free to contact either of us, or your staff may also contact Aldo Marin, Manager, DCFS Board Relations Section, at (213) 351-5530 or Wesley Ford, Director of DPH Children's Medical Services at (626) 569-6001.

PLB:JEF
CS:HB:WF:AR

Attachments

c: Chief Executive Office
County Counsel
Executive Officer, Board of Supervisors

ATTACHMENT A

Attachment A

COMPARISON OF DCFS AND DPH NURSING PROGRAMS

Population	Program Goal	Funding Source	Program Financing	Scope of Practice	Number of Staff	Training	Supervision	Documentation	Data Collection & Analysis	Resources/ Support Staff & Supplies
DEPARTMENT OF CHILDREN AND FAMILIES SERVICES (DCFS)										
-Children in Emergency Response Referrals -Children residing in home of parent, both court supervised, voluntary family maintenance -Children in voluntary family reunification -Children with legal guardian, not-court supervised -Other permanently placed children without court supervision	The mission of the DCFS PHN Program is to promote health, safety and well-being, prevent disease, and facilitate the provision of health care for children and families served by DCFS, allowing children to grow physically and emotionally healthy.	Title XIX, State General Fund, NCC. Skilled Professional Medical Personnel (SPMP) costs claimed for enhanced FFP at the 75% rate Title XIX must meet the requirements of Medicaid regulation [Code of Federal Regulations 42, Section 432.50(d)].	Services rendered by an SPMP must be to a Medi-Cal eligible individual and be a qualifying activity in order to be claimed and reimbursed at the enhanced FFP level (i.e., 75% Federal). DCFS SPMP staff submit their time study hours quarterly based on their activities. Those hours are reported through a County Expense Claim (CEC). Time Study is a methodology that State uses to allocate costs to different programs.	The PHN scope of practice is set by Title XIX in accordance with the American Nurses Association's Public Health Nursing: Scope of Standards Practice. Additionally, the California Department of Social Services, which allocates program funds, has established additional parameters for the scope of practice as follows: 1) The DCFS PHNs consult with CSWs regarding the health care and safety needs of children as they enter the foster care system, during the investigative phase, including voluntary family maintenance, family maintenance and voluntary reunification cases; 2) The DCFS PHNs provide home, office, hospital, and school visits as needed; 3) Provides administrative coordination of the health care needs of children in the home of parent, both court supervised and voluntary family maintenance, in emergency response referrals, voluntary family reunification, children with legal guardian, (not court supervised), and other permanently placed children without court supervision; 4) Updates the Child Welfare Services/Case Management System (CWS/CMS) Health Education Passport (HEP), including prescribed medications, and shares medical information as appropriate and consults with physicians and other medical and non-medical professionals; 5) Serves as a resource to facilitate referrals to early intervention and specialty providers, dentists, and mental health providers, and coordinates health care services; 6) Evaluates the adequacy, accessibility, and availability of health care services to address the health needs of children; 7) Interprets health care reports for CSWs and others as needed; 8) Collaborates with CSWs, biological parents and substitute care providers to ensure all necessary medical/health information is available to those persons responsible for	-1 Nurse Manager -10 PHNS -74 PHNs - 9 ITCs - 1 Secretary **Total 95**	1) DCFS PHNs participate in collaboration with the DPH PHNs to provide trainings to CSW Core Academy trainees on the role of the PHN; 2) DCFS PHNs provide F-Rate trainings to foster parents and relative caregivers to assist them to become certified to care for the medically fragile children under DCFS supervision; 3) PHNs receive continuing education classes, both elective and mandatory, which are provided by DCFS and community partners. 4) New staff shadow senior PHNs, attend 1:1 training sessions provided by the PHNS and complete on line training sessions provided by DCFS. 5)Trainings cover practice in home, office, school and hospital visits, documentation in CWS/CMS, field visits to community partners, review of DCFS health and safety policies, and review of DCFS PHN procedures. The initial phase of training lasts approximately 3 months. Units are assigned between 3–5 months after hire date. 6) DCFS has over thirty policies and procedural guides that provide program standards and operating procedures to carry out the day to day functions and requirements. **(For more specific information on the**	The DCFS Nursing Program operates under the direction of the DCFS Medical Director. The Nurse Manager provides overall program management; and is assisted by 10 PHN Supervisors.	PHNs document information in the CWS/CMS system and provide specialized rate recommendations to the Post Adoption Services Unit using a PHN Progress Note format.	PHNs maintain daily and monthly logs; submit monthly reports of their work to the PHNS. The PHNS reviews, summarizes and submits the information monthly to the Nurse Manager. The Nurse Manager submits a monthly report to the Medical Director. DCFS is in the process of convening a workgroup consisting of PHNSs and departmental research staff to develop a standardized PHN tool to assess acuity and track specific health care needs of children under DCFS supervision. **(Attachments F and G provide workload data for DCFS and DPH consultations**	As per the Memorandum of Understanding between DCFS, Probation, and DPH, DCFS provides space, supplies, furniture, equipment, telephones, fax and other communication equipment required by out-stationed PHNs and their clerical support Clerical support staff includes one Secretary, Senior Typist Clerk and nine ITCs. The ITCs process medical documentation for both the DCFS and DPH Nursing Programs.

COMPARISON OF DCFS AND DPH NURSING PROGRAMS

Population	Program Goal	Funding Source	Program Financing	Scope of Practice	Number of Staff	Training	Supervision	Documentation	Data Collection & Analysis	Resources/ Support Staff & Supplies
				providing health care for the child; 9) Collaborates with CSWs and care providers to develop a system of tracking and follow up health care status; 10) Educates CSWs and parents about the health care needs of children; 11) Attends TDMs, hospital case conferences and other multidisciplinary team conferences to discuss health care concerns and implement safety plans; 12) Works collaboratively with the CSWs to ensure health needs of high risk youth are met under the supervision of DCFS. 13) HUB PHNs are out-stationed at medical hub clinics in seven (7) locations. These PHNs act as liaisons between medical hubs, the PHNs and CSWs in the DCFS regional offices with the goal of improving information sharing in order to assist, facilitate and expedite care coordination related to children referred by DCFS to the medical hubs. 13) After-hours PHN consultation services provide after-hour services on nights, weekends, and holidays to DCFS staff. **(For more specific information on PHN duties and responsibilities, please refer to Attachment D.)**		**training PHNs receive as well as procedural guides and policies, please refer to Attachment I.)**			**for the two programs for Fiscal Year (FY) 2012-13.)**	
DEPARTMENT OF PUBLIC HEALTH (DPH)										
Children with court-ordered detainment, placed out of the home of parent, including children in: Relative/Non-relative Extended Family Member Home; Foster Family Home; Foster Family Agency (FFA)	Goal of the Health Care Program for Children in Foster Care (HCPCFC) is to provide PHN consultation services to Children's Social Workers (CSWs) to identify, prevent, and manage health	State General Funds, County General Funds and Title XIX of the federal Social Security Act. Section 16501.3 of the Welfare and Institution code limits HCPCFC PHN services to those services for which enhanced federal reimbursement may be claimed under Title XIX of the	Financing is based on a 25:75 cost sharing ratio between State/County and federal governments for enhanced activities by SPMP that are allowable under FFP of Title XIX. That is, for every State/County $1 allocated to the HCPCFC program the County receives	The PHN scope of practice is set by Title XIX in accordance with the American Nurses Association's Public Health Nursing: Scope of Standards of Practice. In addition, the California Department of Social Services, which allocates program funds, has established additional parameters for the scope of practice as follows: 1) Provides administrative coordination of the health care needs of children in foster care, including their developmental, dental and mental health needs; 2) Supports adherence to the health assessment periodicity schedule specified in the	-1 Nurse Manager -8 PHN Supervisors -73 PHNs -1 STC -7 ITCs **Total 90**	New PHNs attend a formal program orientation provided by a nurse instructor from the Children's Medical Services (CMS) Staff Development and Training Unit. The training lasts six (6) weeks (two (2) weeks of didactic and four (4) weeks of field training). Didactic training includes: 1) A review of foster care policies and procedures; 2) Introduction to all aspects of the FC program such as: essential documentation, and the State and DCFS database	The HCPCFC is administered locally under the Child Health and Disability Prevention (CHDP) Program, as required by the State. A Nurse Manager provides overall supervision; she is assisted by eight (8) PHN	PHNs document information in CWS/CMS and the FC CMS Portal Program. They also provide CSWs with follow-up information in the Case Folder and keep personal records of contact notes.	PHNs enter data into the CMS FC Portal Program and into the CMS State Branch's Statistical Reporting System (STS). Currently use data from CMS FC Portal Program to analyze workload. Currently working with	The HCPCFC program funding provides monies to support the PHN and clerical positions; no program funding is available for space, supplies, or equipment.

COMPARISON OF DCFS AND DPH NURSING PROGRAMS

Population	Program Goal	Funding Source	Program Financing	Scope of Practice	Number of Staff	Training	Supervision	Documentation	Data Collection & Analysis	Resources/ Support Staff & Supplies
Certified Home; Small Family Home; Group Home; Adoptive Home Not Finalized; and Tribal Court-Specified Home. Children permanently placed until termination of court supervision. Court-supervised children with legal guardian. Children removed from the home for more than sixty days. Children in Probation. Juvenile Court coordinated health services referrals	conditions to enhance the physical, mental and developmental well-being of children in the child welfare system and to enhance child safety.	Social Security Act for services delivered by skilled professional medical personnel (SPMP). Under federal Medicaid regulations enhanced reimbursement for Title XIX Federal Financial Participation (FFP) is available only to state or local agencies that directly administer the Medi-Cal program.	$3 in federal matching funds for allowable FFP activities. Cost reports - based on time studies that document SPMP time spent on allowable FFP enhanced activities - are submitted quarterly to State to receive FFP matching funds.	Child Health and Disability Prevention (CHDP) Program's Health Assessment Guidelines and ensures that the identified health needs are monitored and that continuity of health care services occurs; 3) Updates the HEP, including prescribed medications, and shares medical information as appropriate and consults with physicians and other medical and non-medical professionals regarding the health and well-being of children in foster care and coordinates appropriate medical treatment; 4) Serves as a resource to facilitate referrals to early intervention providers, specialty providers, dentists and mental health providers, and coordinates health care services in a timely manner for children in foster care; 5) Evaluates the adequacy, accessibility, and availability of health care services to address the health care needs of children placed in out-of-home care; 6) Interprets health care reports for CSWs and Probation Officers (POs) and others as needed; 7) Collaborates with CSWs/POs, biological parents (when available) and substitute care providers to ensure that all necessary medical/health care information is available to those persons responsible for providing health care for the child; 8) Assists CSWs assess suitability of foster care placement given the child's health care needs; 9) Collaborates with CSWs/POs and care providers to develop a system of tracking and follow-up of health care status; 10) Educates CSWs, POs and Foster Care (FC) Parents about the health care needs of children in foster care; 11) Attends MAT, TDM and other multidisciplinary team conferences to discuss health care concerns of FC children; and 12) Follows-up on FC children from initial consultation until completion of all required services.		systems; and 3) Mandatory trainings required by DPH. Field training includes: 1) CWS/CMS program training; 2) PM-160 health care assessment and data interpretation and entry; 3) PMA updates, follow up and data entry; 4) Coordination of referrals for health care services; 5) TDM – Health Care Consultation and identification of health care needs and resources; 6) F-rate evaluation and determination; and 7) Attendance at continuing education classes, and elective and mandatory trainings.	Supervisors. The CMS Nursing Director provides guidance to the program on standard nursing practices.		DCFS to obtain CWS/CMS data in order to analyze outcome measures specific to the DPH HCPCFC program.	

ATTACHMENT B

A DESCRIPTION OF THE ROLES AND RESPONSIBILITIES OF PUBLIC HEALTH NURSES (PHNs) WORKING WITH YOUTHS UNDER COURT JURISDICTION AND/OR DCFS SUPERVISION, INCLUDING TASKS THAT THESE PHNs CURRENTLY PERFORM:

- The DCFS PHN(s) are located throughout the 20 DCFS Offices. DCFS PHN (s) also function in the role of After Hours PHN to offer consultation services to the ERCP (Emergency Response Command Post) and Regional offices after regular business hours, weekends and holidays. Throughout March and April 2013, the DCFS PHN(s) further expanded the PHN services to include having a PHN stationed at each of the seven HUB locations to serve as a PHN HUB Liaison, an integral part of the Medical HUB team.

- DCFS PHN(s) are responsible for responding to requests for PHN consultations from CSWs on all children residing in the home with a biological parent or Legal Guardian. The types of cases worked on include ER (Emergency Response) referrals, VFM (Voluntary Family Maintenance), FM (Family Maintenance) Court Home of Parent Cases, VFR (Voluntary Family Reunification), Voluntary PP (Permanent Placement) Non-Court, Kin-Gap, Non-Court Probate, and PAS (Post Adoption Services) cases.

- A consultation consists of a discussion/conversation with the CSW about the child's medical/developmental problems and often results in a joint face to face visit with the CSW and the child in the home, office, school or hospital. DCFS PHN(s) visit a child post hospitalization to ensure the medical needs are being met for the child once they are discharged from a hospital setting back to their home. The PHN obtains medical information to verify that adequate post hospitalization follow-up care is being completed for the child.

- A consultation may also include: review of medical records, consultation with medical providers to obtain/clarify child's medical condition, document medical information into the Health Notebook in CWS/CMS (Child Welfare System/Case management System, a statewide database computer program), providing recommendations about the child's medical/developmental needs and assisting in coordination of necessary medical follow-up for the child's well being.

- DCFS PHNs work in conjunction with the CSW on ER referrals through consultation with ER CSWs as an integral part of the JRR (Joint Response Referral) process during the investigative phase for ER referrals on children with known or suspected medical or developmental problems. The joint response is designed to increase the health and safety outcomes for children and must take place prior to the closure of the ER referral. The goal of the PHN and CSW's dual response is to collaborate on a plan that protects the child's health and safety needs through the use of Structured Decision Making while preserving the family whenever possible. For ER referrals regarding serious medical problems such as Diabetes, Shaken Baby Syndrome, Failure to Thrive; and/or allegations of severe neglect or an allegations of general neglect where it is determined that a child has a known or suspected medical or developmental problems, a consultation with the PHN is mandatory for the CSW.

- Another function of a DCFS PHN is to work with the Continuing Services CSWs on open VFM, FM, VFR, Court Probate, and Non Court Permanent Placements cases. The PHN(s) are consulting with the case carrying CSWs regarding those children with known or suspected medical/developmental conditions under DCFS supervision.

- DCFS PHNs work on Critical Incidents and Child Fatalities assigned to the ER and Continuing Services units and provide a medical report on the status of the child's medical condition to the Medical Director from the Bureau of Clinical Resources and Services. The PHN(s) collaborate with the CSW to assist in gathering information that is crucial on these high profile cases. The PHN(s) respond through a joint visit and obtain both current and past medical information on the focus child as well as the siblings involved in the referral or case. Part of the responsibilities of the PHN, includes a joint home visit with the CSW to assess the medical/developmental needs of the family and to assist in coordinating appropriate and necessary medical services for the children and the family.

- Hospitalized children are followed by DCFS PHN(s) and are tracked and monitored on a weekly basis. The PHN provides current updates to the CSW, SCSW, and the Office of the Medical Director. The focus of the hospital tracking is to facilitate prevention of hospital overstays and to help assess the readiness for timely hospital discharge through coordination and communication with the hospital staff. The PHN works with the CSW and the hospital staff to assess and ensure that all necessary services are in place to facilitate timely discharge; conducts a joint home visit with the CSW post hospital discharge to assess the caregiver's ability to meet the child's ongoing medical needs; facilitates continuity of care and assists in coordinating necessary medical care follow-up appointments and services are being arranged for the child post hospital stay.

- PHN staff works with the medically fragile children through home visits and the review of medical records for children with serious and/or chronic medical conditions. The PHN(s) collaborate with the CSW(s) to assess for the need to transfer the case to MCMS (Medical Case Management Services) and to determine eligibility for F-Rate (medically fragile rate) for caregivers. The PHN is needed to determine and recommend whether the child should be serviced by MCMS, a specialty unit within DCFS that solely focuses on children with high acuity medical needs and the maintenance of their special needs in terms of care and follow-up required to maintain a child with medically fragile conditions.

- DCFS PHN(s) are part of the case conference team for TDM (Team Decision Making) meetings and other case conferences within DCFS and outside sources to discuss the medical and/or developmental needs of the children and how the social issues may be impeding the parent or caregiver's ability to allow the child to reach their full potential regarding their health. The PHN brings a unique medical perspective to these case conferences.

- The PHN spends a great deal of time interpreting and entering medical records into the CWS/CMS database. CSW(s) rely heavily on the PHN's medical expertise to read and interpret the information provided in the medical records that come from a variety of sources (i.e. the hospital, ER visits, MD office, Specialty care providers, immunization records, HUB results, and SCAN (Suspected Child Abuse and Neglect) forensic exams. The PHN may also review records from Regional Center, the school, and the vendors that provide services for occupational, speech, and physical therapy. The PHN has a crucial role in deciphering the numerous pages of medical records received and determining if the information provided would cause the department to have concerns about suspected child abuse and neglect. The ER referrals concerning medical neglect require PHN expertise to support the CSW in determining whether the allegations are substantiated or unfounded. The PHN assists the CSW to determine if the child has any unmet medical needs and if there are areas that require the parent or caregiver to improve or seek further follow-up care for the child. DCFS

PHNs enter the medical records to assist DCFS to maintain the computerized records within the CWS/CMS database. PHN(s) enter into the Health Notebook and then either create or update the HEP (Health Education Passport), which follows the child from caregiver to caregiver throughout their lifetime while being under the jurisdiction and supervision of DCFS. The CSW(s) and other ancillary departments rely on the information entered by the PHN into the HEP to inform them about the diagnoses, medications, hospitalizations, immunizations, birth history, and any other pertinent medical information regarding a child in the DCFS system.

- The review of medical information to determine F-Rate eligibility for benefits to PAS (Post Adoption Services) and Kin-ship cases is performed by the DCFS PHN. The F-Rate is also completed prior to a detention of a medically fragile child to allow the MCMS intake section of DCFS to identify and locate adequate medically fragile foster home placements for the children once removed from their parent's care.

- DCFS PHN(s) participate in collaboration with the DPH PHN(s) to provide trainings to CSW Core Academy trainees on the role of the PHN. DCFS PHN(s) also provide F-Rate trainings to Foster Parents and Relative Caregivers to assist the caregivers to become certified to allow them to care for the medically fragile children that DCFS services.

- The After Hours Stand-By PHN program is staffed with DCFS PHN and PHNS staff to support child safety to ERCP (Emergency Response Command Post) and other Regional office CSW staff after normal business hours, on weekends, and on holidays. The After-Hours PHN provides phone consultation services during the hours in which an office PHN is not available. The After-Hours PHN facilitates continuity of care and the sharing of information to the Regional office PHN to allow for better follow-up once the ER referral is transferred from ERCP to the designated region. The PHN(s) also allow for increased timeliness in communication of medical needs of the children included in ER referrals coming from the ERCP to the regional offices.

- The Hub PHN(s) are out-stationed at medical hub clinics in seven locations (High Desert Health Systems located in Lancaster, Olive View Medical Center, Children's Hospital of Los Angeles, Los Angeles County USC Violence Intervention Program and Community Based Assessment Treatment Center, San Gabriel Satellite in El Monte, Martin Luther King, and Harbor UCLA Child Crisis Center. These PHN(s) act as liaisons between Medical Hubs, PHN(s) and social workers in the DCFS Regional Offices with the goal of improving information sharing in order to assist, facilitate and expedite care coordination related to children referred by DCFS to the Medical Hubs. Hub PHN(s) provide information related to Hub exam results and recommendations for follow-up, request records or information needed by Hub medical providers, and track status of follow-up recommendations. An initial medical exam (Hub exam) is required for all children who enter the DCFS foster care system. The Hub PHN(s) assist with medical record collection to allow the Hub providers to obtain a complete picture before completing forensic exams to rule out suspected child abuse and neglect.

- The Hub PHN duties include, but are not limited to:
  1) Identify and prioritize health care follow-up and care coordination needs for children served by the Medical Hub through regular communication with Medical Hub staff and use of professional expertise in review of Hub medical examination results

2) For cases with an immediate or high priority need, provide care coordination services for conditions found during Medical Hub assessments, to include medical, dental, nutritional, developmental and mental health needs
3) Care coordination to assist in maintaining compliance with Hub medical providers plans/recommendations and specialty referral follow-ups
4) Address barriers that impact continuity of health care services
5) Communicating with Regional Center, CCS (California Children's Services), Fetal Alcohol Syndrome clinic services, and other agencies
6) Coordinating with regional CSW on HIV consent process
7) Follow-up with recommended tests and referrals
8) Verifying support services for medically fragile children
9) Providing health education resources and anticipatory guidance
10) Document care coordination activities and information in both EmHub (electronic documentation system for the Hubs) and CWS/CMS for DCFS
11) Communicate with assigned Regional Office PHN

- In conclusion, as part of the DCFS team, a DCFS PHN will add on to CWS/CMS as a Secondary Assignment. The PHN provides nursing expertise through consults with the CSW to allow collaboration between multiple disciplines and to be part of a team that ensures the children we serve have their medical, dental, psychosocial, education, and developmental needs met. DCFS PHN(s) also believe in the Core Values imbedded within DCFS to include the vision of children thriving in safe families and supportive communities. The DCFS PHN program supports the goal of the uniform service delivery model that improves outcomes in child safety, permanency, and access to effective and caring services. We value the need to be culturally sensitive, while maintaining leadership, accountability, integrity, and responsiveness to allow the DCFS children to have their health needs met in a safe and healthy home.

ATTACHMENT C

HCPCFC Public Health Nurse
Duty Statement
County of Los Angeles —Department of Public Health
Health Care Program for Children in Foster Care (HCPCFC)

SCOPE OF RESPONSIBILITY:

The Health Care Program for Children in Foster Care (HCPCFC) Public Health Nurse (PHN) is a bachelor's degree register nurse who provides nursing services to promote the well being of children in foster care and their families. The HCPCFC PHN seeks to prevent disease, disability, and premature death of foster children, and improve their quality of life allowing them to grow up physically and emotionally healthy. The HCPCFC PHN focuses efforts on those activities that help achieve program public health improvement objectives as determined by the HCPCFC Program in collaboration with the Service Planning Area (SPA) Public Health Team and other community partners.
The HCPCFC PHN reports to a Public Health Nursing Supervisor and/or Nurse Manager.

Examples of duties:

Assessment: The HCPCFC PHN assesses the health status and quality of life of the children in foster care by using data, community resource identification, input from the population and professional judgement.

- PHN initiates medical administrative case consultation.
- Use skilled medical professional expertise in the review of health records to identify and prioritize follow-up on needed health care services.
- Educates foster care parent/guardians on the availability and methods to access the heath care system.
- Interprets the results of health examinations and explains diagnosis and makes recommendations as required for clear communication and understanding.
- Monitors the health status and quality of life of children in foster care to identify community health problems related to program public health improvement objectives and brings these problems to the attention of supervision.
- Evaluates and prioritizes caseload according to the PHN Practice Manual guidelines and the needs of foster children.
- Participates in the foster child's multidisciplinary team meeting as needed to establish a plan of care.
- Identifies community assets and available resources to achieve HCPCFC public health improvement objectives.
- Makes home, office, school, and hospital visits when appropriate.
- Maintains thoroughness, timeliness, and appropriateness of interventions for all consultations.
- Conducts training and education to Children's Social Workers (CSW), Substitute Care Providers (SCP), and other community partners.
- Participates in program planning and policy development.

- Participates in assessment activities such as data analysis and surveillance of the children in foster care in order to determine the scope of focus of the HCPCFC public health improvement objectives.
- Applies scientific knowledge and considers the determinants of health, including client and families' values, beliefs, meaning of health and community resources based on principals stated in the Public Health Nursing Manual.
- Assists in the analysis of programmatic service requirements based on morbidity, human resources, and the number of children in the foster care system.
- Documents relevant data in the Children's Welfare System/Case Management System (CWS/CMS)
- Maintains current knowledge of state and federal laws and regulations that impact Foster Children and Public Health Nursing Practice.
- Identifies the role of cultural, social, and behavioral factors in determining the delivery of public health services.
- Assists supervision in identifying training needs.
- Participates in new staff orientation.

Diagnosis: The HCPCFC PHN analyzes collected assessment data related to the Foster Care population and partners within the community to attach meaning to the date and determine opportunities and needs.

- Defines a problem.
- Identify, investigates and responds to health problems and hazards within the Foster Care population as directed by supervision in order to assist in setting priorities for public health nursing action based on HCPCFC health improvement objectives related to community and systems level interventions.
- Interprets and shares data with policymakers and other partners to improve the quality of health for the Foster Care population.
- Identifies and uses risk and trend data of the Foster Care population to refocus/redirect health improvement efforts among this population.
- In partnership with the community, identifies/prioritizes opportunities and needs of the Foster Care population amenable to public health nursing interventions and shares these insights with supervision.
- Documents opportunities and needs to improve the quality of care of the Foster care population, which facilitates the determination of expected outcomes and satisfies performance measure standards.
- Adheres to state and federal public health laws, regulations and policies.
- Gathers field, clinical, and other statistics within HCPCFC.
- Participates in determining the needs for development and training of staff.
- Assists supervision in determining material, equipment and facilities needed to accomplish HCPCFC improvement objectives.

- Selects and defines variables relevant to defined public health problems within the foster care population.
- Gives professional direction to public health orientees and non-nursing employees as needed.
- Partners with community to attach meaning to collected qualitative and quantitative data.
- Make relevant inferences from qualitative and quantitative data

Outcomes identification: The HCPCFC PHN participates with community partners and the HCPCFC public health team to identify expected outcomes for children in foster care and their health status.

- Identifies levels of expected health status changes for the foster care child/family, and the community as a whole.
- States outcomes that are clear for the foster child and family, that are culturally appropriate, and documented in measurable terms.
- Accomplishes effective community engagements, by ensuring that outcomes are supported by HCPCFC guidelines, plans, and standards.
- Design outcomes that reflect the contributions of the partners involved in the achievement of those outcomes.
- Ensures that outcomes are attainable in relation to available resources.
- Assesses outcomes in collaboration/ coordination with the HCPCFC public health team, SPA public health, and the key stakeholders in the community.
- Ensures that outcomes have a time estimate for attainment.

Planning: The HCPCFC PHN promotes and supports the development of programs, policies and services that provide interventions to improve the health status and quality of life for all the children in foster care as defined by the program's public health objectives.

- Participates in the development of policies and plans that support efforts by the community to improve the health status of the foster children as defined by the Program's public health objectives.
- Leads and/or participates in community groups to address public health issues that impact foster children.
- Provides consultation to the SPA public health team about "best practices" related to foster care program's public health improvement objectives.
- Gives priority to plans that promote the greatest improvement in the health of children in foster care.
- Adapts and develops approaches to problems that take into consideration cultural differences and preferences of the multiple communities.
- Utilizes leadership, team building, negotiation, and conflict resolution skills to build community partnerships.
- Engages in community outreache and meetings.

- Utilizes effective methods for interacting sensitively, effectively, and professionally with persons from diverse cultural, socioeconomic, educational, racial, ethnic, and professional backgrounds, and persons of all ages and lifestyle preference.
- Inform key policy makers of the impact of health regulation, budget decisions, and other factors on the health of foster children.
- Prepares and participates in emergency response plans.
- Ensures that the plans reflect best practices of current public health nursing practice.
- Coordinates with supervision in documenting all plans, programs, and intervention strategies.
- Plans and/or coordinates training/in-service education to meet the population and community needs.
- Participates in social marketing events identified as venues to increase public knowledge regarding services provided by the HCPCFC.
- Develops, implements, and evaluates a public health assessment for children in foster care.
- Contributes to development, implementation, and monitoring of organizational performance standards.

Implementation: The HCPCFC PHN assures access and availability of programs, policies, resources and services to the foster care population as defined by the public health improvement objectives.

- Establishes and maintains contact with SPAs, community partners, families, and individuals as needed to achieve public health improvement objectives.
- Assists in focusing community partner and SPA efforts on achieving HCPCFC public health improvement objectives using collaboration, coalition building and other effective public health nursing interventions.
- Carries out the policies and plans established by the program that support community efforts to improve the health status and quality of life of the children as defined by the HCPCFC public health improvement objectives.
- Ensures that all interventions are consistent with established policies, plans and services.
- Helps to ensure that resources are directed toward groups identified as being at highest risk of disease and disability.
- Acts as the resource person for public health nursing and other public health disciplines on community resources and community infrastructure related to children in foster care to facilitate efforts at the community and system levels of practice to achieve the HCPCFC public health improvement objectives.
- Documents plans and activities related to achieving the HCPCFC public health improvement objectives.
- May be assigned to specific community partnership projects, under the oversight of supervision.
- Applies ethical principles to the collection, maintenance, use, and dissemination of data and information.

- Applies data collection processes, information technology applications, and computer systems storage/retrieval strategies.
- Effectively presents accurate demographic, statistical, programmatic, and scientific, information for professional and lay audiences.
- Listens to others in an unbiased manner, respects point of view of others, and promotes the expression of diverse opinions and perspectives.
- Understands the dynamic forces contributing to cultural diversity.
- Understands the importance of a diverse public health workforce.
- Collaborates with community partners to promote the health of the population.
- Promotes team and organizational learning.
- Applies theory of organizational structures to professional practice.

Evaluation: The HCPCFC PHN evaluates the health status of children in foster care as defined by the HCPCFC public health improvement objectives.

- Participates in reviewing the work and caseload of the HCPCFC PHNs and/or other assigned personnel.
- Assists in periodically evaluating improvement objectives of health indicators for children in foster care based on the program staff and community partners' efforts in achieving the public health improvement objectives.
- Participates in research in to new insights and innovative solutions (best practices) to health and quality of life concerns of the population of interest as defined by the HCPCFC public health improvement objectives.
- Evaluates collected data using scientific methods to determine the effectiveness of public health nursing interventions.
- Ensures that evaluation is systematic and ongoing.
- Uses collected information to improve existing policies, programs, and services, and as a part of the next community assessment.
- Examines the effectiveness of all intervention, including the need for modification of interventions, in relation to outcomes.
- Documents the evaluation processes and the population's response to policies, plans, and interventions.
- Evaluates the integrity and comparability of data and identifies gaps in data sources.

The HCPCFC PHN may have other duties assigned.

Other:

In the event of an emergency, employee shall report
for emergency-related duties once their critical personal
and family emergency responsibilities have been met.

HCPCFC Public Health Nurse
Duty Statement
County of Los Angeles —Department of Public Health
Health Care Program for Children in Foster Care (HCPCFC)

Duty Statement Verification

I have received a copy of the duty statement for my position of HCPCFC PHN. I have read all the information in the duty statement and understand that I am expected to perform at the level of work described. My supervisor has answered my questions and clarified any areas that may be of concern. If I have any questions in the future, I understand that I am to consult with my supervisor.

_____ _____

Employee Signature Date

_____

Employee Name (print)

_____ _____

Supervisor Signature Date

_____

Supervisor Name (print)

APPROVED BY : *CMS Nursing Director* *EEFECTIVE DATE:* *REVISED DATE : 4/1/11*

ATTACHMENT D

DCFS NURSING PROGRAM – POLICIES AND PROCEDURES LIST

Procedural Guide 0070 - 560.05
Joint Response Referral

Procedural Guide 0600 - 530.00
Public Health Nurse & Roles of Responsibilities and Secondary Assignment in the Child Welfare Services/Case Management System

Procedural Guide 0600 - 506.00
Prompting Children's Physical Well-being and Health

Public Health Nurse Referral Procedure
(DCFS PHN Program Procedural Guide)

Procedural Guide 0070 - 521.11
Assessment of Medical Neglect

Procedural Guide 0070 - 524.10
Assessment of Failure To Thrive

Procedural Guide 0070 - 525.10
Assessment of Shaken Infant Syndrome

Procedural Guide 0070 - 526.10
Assessment of Fetal Spectrum Disorder

Procedural Guide 0070 - 516.10
Assessing the Development and Referring to and Collaborating with Regional Center

Procedural Guide 0600 - 500.00
Utilization of Medical HUBS

Procedural Guide 0600 - 505.20
Medical Hospitalization and/or Discharge Of DCFS-Supervised Children

Procedural Guide 0600 - 505.10
Assessment of and Services for Children with Special Health Care Needs

Procedural Guide 0600 - 507.10
Youth Reproductive Health & Pregnancy

Procedural Guide 0400 - 503.05
Standards for Documenting Contacts

Procedural Guide 0600 - 514.10
Psychotropic Medication Authorization Review and Monitoring for DCFS Supervised Children

Procedural Guide 0070 - 548.06
Emergency Response Referrals Alleging Physical Abuse of Children Who Are Under DCFS Supervision

Procedural Guide 0600 - 500.10
Reducing the Threat of Infection by Blood-Borne Pathogens and Communicable Diseases: Universal Precautions

Procedural Guide 0900 - 522.11
Specialized Care Increment (SCI) – F-Rate

Nurse to Nurse Report Form

Procedural Guide 0200 - 518.10
Post-Adoption Services (PAS) Release of Information After the Adoption is Final

Executive Team Recommendations and Emergency Response

Procedural Guide 0080 - 505.20
Health and Education Passport (HEP)

Procedural Guide 0600 - 506.10
Child Health and Disability Prevention (CHDP) Program

Procedural Guide 0070 - 528.10
Assessment of Medical, Educational and Mental Health Special Needs

ATTACHMENT E

COUNTY OF LOS ANGELES
CHILDREN'S MEDICAL SERVICES
HEALTH CARE PROGRAM FOR CHILDREN IN FOSTER CARE (HCPCFC)

CMS
HCPCFC

Policy/Procedure

SUBJECT: PUBLIC HEALTH NURSE FOSTER CARE CHILD HOME VISIT

PURPOSE:

To establish a standardized protocol for all the visits made to the children in the Health Care Program for Children in Foster Care (HCPCFC).

SCOPE:

Responsibilities of the Public Health Nurse Supervisor (PHNS) and Public Health Nurse (PHN) when making a foster care child home visit.

DEFINITION:

Child – a foster care child in the HCPCFC out of home of parent with a court order.
Visit – a joint visit by a Public Health Nurse and Children's Social Worker (CSW) to a child's home, school, office, hospital or any location.

POLICY:

The PHN will adhere to the established policy and procedure when making a visit.

The PHN and PHNS will refer to the Guidelines for Foster Care Public Health Nurses: Consultation and Care Coordination for Out of County Placements (attachment E) when there is a request from the CSW to make a home visit to a child placed out of county.

The PHN and PHNS will determine if a visit is the appropriate course of action to assess the health care needs of the child/children.

The PHN will notify the PHNS of a pending visit prior to the child home visit via e-mail, telephone call, or in person.

The PHN will make foster care child home visits jointly with a CSW or the Supervising Children's Social Worker (SCSW).

The PHN will discuss with the CSW, and obtain approval from the PHNS, if an independent PHN follow-up visit is needed.

The PHN will assess and evaluate the child's medical/health information prior to the child's home visit.

The PHN will complete the route sheet (attachment A) and place a copy visibly on his/her desk and notify the PHNS and co-workers of the foster care child visit prior to each child home visit.

If the PHN is in a different location than the PHNS, notify the PHNS and e-mail the route sheet prior to the visit.

The PHN will not be involved in the disrobing of foster care children (refer to DCFS policy# 0070-531.10; #0070-560.05).

The PHN will utilize assessment skills to identify the child's actual and/or potential health needs.

The PHN will not engage in direct patient care, i.e., taking vital signs, giving injections, bandaging wounds, or diagnosing any health condition (refer to DCFS policy# 0070-560.05).

The PHN will use his/her personal vehicle every time to make a foster care child home visit.

The PHN will not engage in transporting foster care children anywhere whether in his/her vehicle or the CSW's vehicle.

PROCEDURE:

1. The PHN determines the need for a foster care child visit with CSW by:
   a. Clarifying with the CSW the purpose of the consultation request.
   b. Assessing the need for a PHN foster care child visit by determining whether the request is within the PHN's scope of nursing practice.

2. If determined that a home visit is not appropriate, the PHN will assist the CSW in identifying other resources for a child health evaluation, such as Medical HUB, Specialty Provider, California Children's Services (CCS), Regional Center, etc.

3. The PHN in collaboration with the CSW assesses the health care needs of the child/children.

4. The PHN reviews and provides the Child Health and Disability Prevention Program (CHDP) brochure for Well Child Exam, and the Growing Up Healthy, and/or child specific medical information as needed (attachment B).

5. The PHN utilizes the Assessment Guideline Tool to assist with completion of the home visit assessment (attachment C).

6. The PHN completes a PHN foster care child visit assessment, and assists the CSW with the appropriate health related referrals as needed. The PHN foster care child visit assessment includes the following areas:

    a. Physical Assessment: The PHN assesses the general physical status of the child, including hygiene status, signs of possible abuse, neglect, and/or failure to thrive.
    b. Nutritional Assessment: The PHN assesses for current or past feeding problems, i.e., food allergies, appetite, type of formula or special diet, amount, frequency, preparation techniques, availability, and age appropriate foods. The PHN assesses elimination pattern, i.e., number of diaper changes and bowel movements per day.
    c. Developmental Assessment: The PHN observes the child for age appropriate milestones. The PHN assesses caregiver's awareness of appropriate developmental milestones, and caregiver's ability to provide age/developmental appropriate activities. The PHN observes for bonding between the caregiver and the child, and evaluates play area and toys for safety and age developmental appropriateness. The PHN assesses the caregiver's awareness of age/developmentally appropriate toileting practices.
    d. Health Assessment: The PHN reviews available medical information to assess if health care needs are being met and make recommendations based on available health information.
    e. Home Environment (internal, external): The PHN assesses the home for cleanliness/clutter and other health care hazards and educates/advises caregiver of findings, i.e., injury/poison prevention, car seat, swimming pool, medication storage, firearms, smoke detectors, peeling paint and safety locks.
    f. Family Assessment: The PHN assesses for actual or potential health problems by assessing the health status of the family. The PHN assesses the family's awareness of community resources as needed, such as Women, Infants and Children (WIC) and CHDP.

7. When a health care concern is identified during a visit, the PHN refers and/or assists the CSW with making the referral to the appropriate agency.

8. When making a home visit, the PHN should observe basic safety precautions by:

    a. Activating 911 in any emergency situation and notifying PHNS.
    b. Observing departmental guidelines as outlined on field safety for PHN.
    c. Notifying PHNS if the child visit goes beyond scheduled working hours.

9. If the PHN determines that interventions other than child visit are more appropriate to meet the health care needs of the child, the PHN informs the CSW and/or SCSW. Appropriate interventions may include, but are not limited to:

    a. Recommendation for the child to be examined by a health care provider/emergency department.
    b. Assistance with health care referrals as needed.

10. Documentation of the PHN foster care child visit:

    a. Utilize PHN Assessment Guideline Tool for all home visits.
    b. Document findings from child visit on the Assessment Progress Note and enter as contact in CWS/CMS (attachment D).
    c. Update CWS/CMS health notebook as indicated.
    d. Provide PHNS with a copy of the PHN foster care child visit Assessment Progress Note and PHN route sheet.
    e. Keep hard copies for your record.

ATTACHMENTS:

A. Public Health Nurse- Route Sheet
B. CHDP- "Well Baby Exam" Birth to 18 months
   CHDP- "Well Child Exam" 2 to 12 years
   CHDP- "Well Teen Exam" 13 to 19 years
   CHDP- "Growing Up Healthy"
C. Public Health Nursing Assessment Guideline Tool
D. Public Health Nursing Assessment Note
E. Guidelines for Public Health Nurses: Consultation and Care Coordination for Out of County Placement

References

Department of Children and Family Services (2010). Procedural Guide 0070-531.10, *Visual Inspection of Children.*

Department of Children and Family Services (2008). Procedural Guide 0070-560.05, *Joint Response Referral.*

Children's Medical Services Staff Development & Training Unit (2007). *Field Safety for PHN. New PHN in HCPCFC.*

County of Los Angeles Public Health. *Child Health and Disability Prevention* (CHDP) *Program Reference Corner.* Retrieved on January 27, 2010 from http://publichealth.lacounty.gov/cms/chdp.htm

APPROVED BY: Susie Millard RN EFFECTVE DATE: 11/29/10
REVISED DATE : _____

ATTACHMENT F

DCFS PHN Annual Stats Report for 2012/2013 (ATTACHMENT F)

	July 2012	August 2012	September 2012	October 2012	November 2012	December 2012	January 2013	February 2013	March 2013	April 2013	May 2013	June 2013	FY12 Total
NUMBER OF PHN's	43	41	36	39	36	38	49	50	53	49.5	49.5	50	
Vacancies/LOA	6	6	5	3	9	9.5	7	6	5	13	9	7.5	
NUMBER OF ITC's	8	8	4	6	6	8	8	7	7	6	7	5	
Vacancies/LOA	1	2	1	2	1	1	1	2	2	4	2	2	
OFFICE ACTIVITIES													
General Staff Meetings	7	12	5	12	10	18	15	19	24	22	23	14	181
Unit Meetings	10	6	4	3	7	5	16	9	11	5	9	5	90
Community Meetings	27	23	14	16	24	34	35	51	51	35	30	39	379
PHN Meetings	2	0	0	1	3	1	7	2	5	11	6	4	42
Inserv/Training Attended	3	18	16	8	3	5	6	16	94	64	102	25	360
Inserv/Training Given	5	2	1	3	9	7	9	4	6	4	4	2	56
Children's Court Subpeona	0	0	0	0	0	0	0	0	0	0	0	0	0
CONSULTATIONS													
< 1 yr	270	272	275	203	246	206	365	261	298	325	385	273	3379
0-36 months	517	562	303	478	333	321	568	584	645	731	665	546	6253
1-4 yrs	595	619	407	523	390	433	703	604	599	790	674	648	6985
5-9 yrs	521	510	453	444	362	374	563	578	590	723	736	704	6558
10-15 yrs	469	481	349	411	348	346	529	510	570	579	657	589	5838
16-18 yrs	131	158	86	124	81	86	136	140	150	192	175	148	1607
> 18 yrs	37	14	14	18	18	165	12	18	26	37	16	23	398
Initial consults	2023	2026	1559	1678	1406	1391	2145	2087	2096	2338	2378	2184	23311
Follow up consults	1303	1548	1306	1746	1409	1314	1843	2224	2298	2510	2445	2169	22115
TOTAL CONSULTS	3326	3574	2865	3424	2815	2705	3988	4311	4394	4848	4823	4353	45426
Home Visits	384	377	271	332	298	296	354	518	423	461	500	511	4725
Office Visits	89	82	77	130	110	71	104	137	160	137	177	103	1377
Hospital Visits	15	13	7	9	6	15	18	13	4	10	6	2	118
School Visits	0	6	5	5	4	2	2	7	0	6	14	2	53
ER Referrals Reviewed	1592	1584	1302	1064	1047	1196	1484	1802	1321	1456	1545	1289	16682
Health Histories Obtained	782	874	419	470	491	428	513	789	758	743	836	685	7788
Med Rec Requested	391	533	471	572	458	349	584	663	670	717	777	653	6838
MD/Health Provider Consults	613	635	348	446	398	424	569	545	659	726	599	536	6498
Community Resource Referrals	133	115	102	138	138	68	194	302	174	284	299	307	2254
PMA's	0	3	0	1	0	6	3	0	2	0	1	1	17
F-Rates	30	28	23	32	31	37	46	71	25	1	45	32	401
PAS Reviews	21	21	24	21	20	26	22	28	24	1	21	19	248
Critical Incident PHN Follow-Up	26	20	12	6	13	28	12	13	17	10	23	19	199
Child Fatality PHN Follow-Up	2	9	4	2	4	5	11	3	10	12	7	8	77
TDM	28	26	19	17	24	39	117	0	0	0	0	0	270
Child Safety	40	14	34	0	148	39	0	0	0	0	0	0	275
Hospital	22	3	26	7	4	4	1	0	0	0	0	0	67
ER High Risk Referral	40	16	33	202	83	150	304	0	0	0	0	0	828
Nurse2Nurse	51	79	43	27	32	60	57	64	90	70	118	69	760
Critical Incident Case Conf	0	5	6	2	8	4	2	0	0	0	0	0	27
Child Fatality Case Conf	0	2	1	0	4	0	0	0	0	0	0	0	7
MAT	0	0	0	0	0	0	0	0	0	0	0	0	0
Other	27	6	34	1	56	58	225	0	0	0	0	0	407
CWS/CMS DATA ENTRY													
Health Notebook	1694	1714	397	0	491	355	809	0	0	0	0	0	5460
HEP New	727	938	689	681	604	618	845	779	843	994	1002	905	9625
HEP Updated	804	835	662	852	712	744	923	1132	1087	1279	968	1013	11011
Contacts	3107	1931	316	0	0	0	0	0	0	0	0	0	5354
ITC ACTIVITIES													
PM 160 / DCFS 561	299	270	110	61	180	144	296	175	134	258	166	167	2260
PMA	21	15	0	0	0	0	0	0	0	0	0	44	80
F-Rate Alerts	31	21	18	9	137	8	21	15	6	12	47	3	328
Medical Records Requested	0	33	54	0	0	2	2	0	15	0	24	0	130
DATA SUMMARIES													
Total Number of Consultations	3326	3574	2865	3424	2815	2705	3988	4311	4394	4848	4823	4353	45426
Avg # Consults/PHN/mo	77	87	80	88	78	71	81	86	83	98	97	87	1013
Total Number of Visits	488	478	360	476	418	384	478	696	622	653	731	646	6430
Avg # Visits/PHN/mo	11	12	10	12	12	10	10	14	12	13	15	13	144
Total # of Conferences	208	151	196	256	359	354	706	164	252	156	239	135	3176
Avg # Conferences/PHN/mo	5	4	5	7	10	9	14	3	5	3	5	3	73
Total DCFS Referrals	10307	11935	13227	14617	11728	9814	11925	11765	12504	14069	15643	11465	148999
Total VFM Cases (HOP)	5555	5358	6371	6470	5047	4927	4590	4623	5609	4946	5203	5762	64461
Total FM Cases (HOP)	8635	8486	4770	4398	7425	9017	8262	8761	8804	8942	9464	8737	95701
Total DCFS Ref +HOP Cases	24497	25779	24368	25485	24200	23758	24777	25149	26917	27957	30310	25964	309161
Caseload Ratio children/PHN	570	629	677	653	672	625	506	503	508	565	612	519	

ATTACHMENT G

Attachment G

HCPCFC - DATA COLLECTION LOG - FY 2012/2013

All Sites / Probation	FY: 2012-2013	JUL	AUG	SEPT	OCT	NOV	DEC	JAN	FEB	MAR	APR	MAY	JUN	TOTAL
Health Passports	New	589	671	562	631	558	573	698	627	520	644	759	421	**7253**
	Updated	3422	3478	3034	3382	2863	2659	3176	2891	3042	3555	3351	2977	**37830**
Up-to-Date	Physical	2487	2542	2275	2473	2151	2081	2579	2396	2292	2686	2777	2201	**28940**
	Dental	1394	1409	1256	1423	1162	1138	1384	1371	1280	1519	1600	1157	**16093**
Imms. Reviewed		3257	3282	2897	3361	2762	2619	3197	2962	2914	3428	3493	2849	**37021**
Consultations	Total	4018	3985	3556	4261	3413	3166	3848	3491	3610	4106	4145	3468	**45067**
	F-rates	182	135	124	149	146	136	142	134	141	150	125	111	**1675**
	AAP-rates	7	13	8	8	12	7	13	13	3	6	12	4	**106**
	D-Rates	3	2	4	5	1	6	15	2	7	0	4	0	**49**
	PMA	380	414	273	424	288	335	341	231	306	391	337	390	**4110**
	561	3633	3730	3437	3834	3316	3008	3898	3830	3535	4331	4645	3182	**44379**
	PM 160 - Total	345	418	445	291	180	225	204	254	156	240	225	363	**3346**
	PM 160 (0-3)	301	366	396	239	156	195	182	230	130	206	204	334	**2939**
	PM 160 (4-5)	44	52	49	52	24	30	22	24	26	34	21	29	**407**
	Medical Records	3589	3510	2984	3722	3164	2790	3458	3325	3306	3795	3694	3132	**40469**
	Referrals	499	712	567	689	561	505	693	623	486	494	545	453	**6827**
	Home Visit	29	26	12	28	13	19	20	30	39	21	13	20	**270**
	No. of Children	38	31	20	34	13	23	32	35	43	35	9	24	**337**
	Office Visit	50	53	42	60	64	68	77	51	69	49	50	99	**732**
	No. of Children	52	53	41	63	67	62	77	50	73	39	50	98	**725**
	Hospital Visit	21	54	25	56	33	14	26	31	39	29	27	22	**377**
	School Visit	8	13	11	6	4	7	27	10	10	10	7	6	**119**
	Other (Specify)	9	13	14	9	1	3	0	0	1	0	0	2	**52**
Medical Home	Within a year	3155	3039	2802	3233	2582	2452	3050	2698	2616	2980	3052	2654	**34313**
Training Provided	CSWs	20	27	40	41	26	23	37	18	37	44	25	54	**392**
Case Conferences	Total	170	230	145	250	233	156	194	140	183	141	167	159	**2168**
Meetings	PHN/DCFS/Unit	95	58	65	91	62	77	89	89	88	54	60	71	**899**
Other	Phones	3099	3219	2487	3119	2876	2329	3076	2842	3503	3645	3361	3529	**37085**
Other	Faxes	744	797	639	812	786	645	855	770	765	800	676	713	**9002**

ATTACHMENT H

DCFS CASE SCENARIOS

Case scenarios of successful examples that DCFS PHNs have worked on and how these tie in with the Department Goals for permanency, access and child safety:

Scenario 1

1. Description of the problem/medical issues
During a joint home visit: CSW decided to detain 3 children from father, because father's speech was slurred. CSW believed father was using illegal drugs.

2. PHN Interventions
Through the PHN's immediate assessment of father it was found out that the father had had previously suffered from a stroke, which caused his speech problem.

3. Outcome
After more history was obtained by the PHN it was discovered that father had a medical condition causing the impairment and the children were allowed to stay in father's care.

4. Departments Goals met by PHN intervention/consultation
Children remained with biological father. No evidence of neglect or abuse was found.
Departmental Goals- safety and permanence.

Scenario 2

1. Description of the problem/medical issues
Referral came in for severe neglect: mom with multiple prior DCFS referrals. The referral involved a 16 month old infant with gastrostomy tube (a tube that is placed into the stomach) for feeding. Mother was providing care for seven children.

2. PHN Interventions
Through consultation with medical providers and a joint home visit, PHN identified that mom was not feeding the infant properly, medical appointment were not being kept, medical equipment and medications were not being re-filled and replenished. PHN also identified that infant was losing weight while with mother, but gained while in the care of the hospital.

3. Outcome
After PHN expressed her concern that the infant was not receiving appropriate care with mother, it was discovered that mother was overwhelmed and could not keep up with the demands of the infant. Eventually there was a court hearing. The child was detained due to the evidence that the care of the infant was unsafe under the care of the mom. The infant was assigned care in an F-rated home and be began to thrive in his new living conditions.

4. Departments Goals met by PHN intervention/consultation
Safety. PHN intervention helped to ensure child received appropriate medical care and services.

DCFS CASE SCENARIOS

Scenario 3

1. Description of the problem/medical issues
Three children living with both parents & maternal grandparents. Children were approximately ages: 7 years-old, 5 years-old & 3 years-old. Mom also pregnant. None of the children were verbal. All the children still wore diapers, age 7 also needed neurology consultation. Only oldest child was received speech therapy through school. Primary medical doctor/pediatrician had requested in multiple referrals for regional center, and neurology specialist. Family had not followed through with the referrals. Children were all overdue for physicals. Only the 7 year-old was up to date with immunizations. Mom was a "stay at home mom" but also had learning disabilities & was eligible to continue receiving assistance through Regional Center, father worked 12+ hours daily. CSW requested PHN assistance after initial contact-CSW knew children were developmentally delayed and other than regional center was unsure how to address children's needs. Family needed assistance navigating/following through with specialist referrals. Family needed education regarding the importance of follow up as recommended.

2. PHN Interventions
PHN reviewed medical records to determine what specialists children needed to see. PHN consulted and followed up with followed up with the children's pediatrician to ensure that referrals had been placed to all specialists. PHN conducted joint home visit with CSW to assess family's needs & strengths so that family would feel empowered to address medical/developmental concerns. At the home visit, PHN assisted family to schedule medical appointments, taught family how to keep track of appointments & assisting family to converse with medical providers so that all appointments were accessible (family had limited transportation). Allowed family to address their concerns, questions & hesitations. Learned language was a barrier & maternal grandmother was unsure of phone numbers to call.

3. Outcome
Maternal grandparents demonstrated understanding by explaining the need for follow up appointments, how to contact clinics and maternal grandmother implemented a system to keep track of all appointments. PHN contacted clinics to ensure appointments were attended. The referral was promoted to a case with the department. Children were linked to and received adequate medical and developmental care.

4. Departments Goals met by PHN intervention/consultation
Safety. PHN's involvement assisted the family to coordinate medical and developmental care for the children. PHN assisted with ensuring adequate medical and developmental services were received.

Scenario 4

1. Description of the problem/medical issues
CSW consulted with PHN only requested that the PHN review and input medical documentation that was obtained form the medical provider.

DCFS CASE SCENARIOS

2. PHN Interventions
During review of the medical record, PHN noted the child had a serious medical condition. The PHN decided to follow up with the medical provider to determine if mom has followed through with the child's medical regimen.

3. Outcome
After consultation with the clinic it was noted that mom did not follow through. The child was not receiving his medications. Joint home visit conducted. Through the PHN's interventions, the child was seen by the medical specialist and was started on his medication.

4. Departments Goals met by PHN intervention/consultation
This minor's safety was secured. Mother was on board and continued to show progress towards being more proactive for her child's medical care.

Scenario 5

1. Description of the problem/medical issues
Newly diagnosed 14 year-old, insulin dependent, diabetic female. Her mother had died in February 2012. Minor was being cared for by an uncle and father who knew nothing about her diabetes. When minor visited the DCFS Palmdale office, the ER CSW was about to close the ER referral because the issue that was being investigated was settled. However, once a PHN checked the girl's blood sugar machine she found that she had only taken 3 blood sugar reading in over one month. PHN also discovered that minor was carrying around and saying she was taking the wrong (almost lethal) combination of insulin regimen 70/30 with Novolog and Lantus. PHN knew that particular combination of insulin was not prescribed together. The child had basically been left to manage her own diabetes without any help from the adults in her life. She became very depressed.

2. PHN Interventions
PHN arranged for both father and uncle to be trained in diabetes care and helped to reconnect the teenager to her endocrinologist (diabetic specialist), who minor had not seen in over 10 months.

3. Outcome
The minor was seen by the same PHN in the DCFS Palmdale office at a later date. Minor seems like a completely different child. The lack of knowledge about the minor's diabetes that the father and caregiver had in combination with wrong insulin being administered by child, could have resulted in serious medical consequences for the child, such as hospitalization, etc. This was avoided through re-education of father and uncle, as coordinated by the PHN. Child remained in father's care.

4. Departments Goals met by PHN intervention/consultation
Safety through coordination of diabetic medical education for minor, minor's father and minor's uncle.

DCFS CASE SCENARIOS

Scenario 6

1. Description of the problem/medical issues
An 8 year-old diabetic male, insulin dependent. Mother slightly developmentally delayed and unable to read. PHN attended a joint home visit in which mother presented a three day diabetic blood sugar written log that mother was giving to clinic to have the endocrinologist (diabetic specialist) make insulin adjustments every three days based on the blood sugar readings.

2. PHN Interventions
When the PHN checked the blood sugar machine (actually 5 different blood sugar machines in the home), it was discovered that mother was faking or making up the blood sugar readings. Had it not been for the PHN, the CSW would have thought mother was doing a really good job in keeping up her handwritten log. Through conference with DCFS Medical Case Management Unit, SCSW and PHN explaining to CSW and SCSW how dangerous this practice of falsifying the minor's blood sugar log was. The minor was detained. On the night minor was detained, PHN asked mom check the minor's blood sugar. It was 546 (normal 80-120). PHN asked minor to check for ketones on a Keto-stick and found mild ketones, meaning he was going into diabetic ketoacidosis and could go into a coma, if he did not receive medical treatment.

3. Outcome
The CSW would not have known to ask mother to check the minor's urine for ketones. The PHN and CSW waited for ambulance and then followed ambulance to emergency room to have minor medically cleared before entering foster care and received intravenous fluids and treatment for his high blood sugar.

4. Departments Goals met by PHN intervention/consultation
The minor's safety was established due to the interventions of the PHN.

ATTACHMENT I

DCFS PHN TRAINING PROGRAM OVERVIEW

- Special Medical Conditions of Asthma, Common Skin Problems, Seizures, and Diabetes Mellitus in Children: For CSWs /PHNs Working with Care Providers

  This half day training will focus on the specialized medical conditions of Asthma, Common Skin Problems, Seizures, and Diabetes Mellitus in children and how CSWs can assist caregivers in recognizing and caring for same. There will be a focus on working with families to provide them with informational support on these topics in support of optimal child health for children with birth families, in foster care, and those in adoptive homes.

- Physical Abuse: A Primer on Bruises, Burns, Fractures and Abusive Head Trauma for CSWs/PHNs

  This half-day training for CSWs/SCSWs/PHNs will focus on the various types of child abuse including bruises, burns, fractures as well as abusive head trauma which is the number one cause of death due to child abuse. This training will discuss the definition of AHT, review of the current understanding of the mechanisms of injury, a review of the intracranial, intraocular and skeletal findings associated with abusive head trauma along with the clinical presentation and symptoms of the victims. Emphasis will be placed on being able to detect the difference between a well-appearing child versus an ill-appearing child by observation of child's growth pattern and developmental capabilities. Video clips and photos will assist in differentiating between the two.

- Secondary Trauma Training for CSWs/SCSW/PHNs

  This half-day training for CSWs/SCSWs/PHNs will focus on defining and understanding Secondary Trauma and its impact on daily work life. This training utilizes didactic, experimental and therapeutic interventions to explore the impact of secondary trauma on staff. Participants will understand the difference between PTSD, Burnout and Secondary Trauma. They will know the risk factors for Social Workers, gain personal insight as to how one might be at risk for secondary trauma, understand the role of resiliency, empathy and post-traumatic growth, acquire personal and learn professional strategies to protect oneself. Emphasis will be placed on understanding the importance of self-care, prevention and strategies for protection from Secondary trauma.

- Maternal Mental Health: Prevention, Assessment and Intervention for CSWs/PHNs

  The perinatal period, spanning the time between conception and the first year following childbirth, encompasses a range of mood disorders that can affect a woman during pregnancy and around the time of birth. Left untreated, maternal depression leads to long-term depression in the mother, a lack of emotional availability for the baby and detrimental outcomes in the development of the fetus, newborn and developing child. The good news is that these conditions are often preventable and highly treatable. This 3-hour training for ER workers will help identify the prevalence, risk factors, assessment methods and treatment modalities most needed when working with women who may be suffering from perinatal mood and anxiety disorders.

DCFS PHN TRAINING PROGRAM OVERVIEW

- Diabetes in children and teens: Current practice and treatments for Public Health Nurses

  This one-day training, specifically designed for Public Health Nurses, will provide participants with information on the latest discoveries and treatments for Type 2 Diabetes in children and adolescents. Experts in the field of Diabetes will present current research findings, new medications and techniques for working with the children served by the Department.

- Why We Do What We Do: Understanding the Fundamental Principles of the WIC 300 Codes and Motivational Interviewing as Tools for Better Practice

  This full-day training provides an overview of information which is fundamental to the role of the DCFS Social Worker and others who have a hand in the provision of service to our clients. The Public Health Nurses will be introduced to the WIC 300 Codes as a principal contributor to the decision made by CSWs to investigate a referral and determine whether to close or open a case. Nurses will also have the opportunity to become familiar with the fundamental use of the Motivational Interviewing model as a technique for quality assessments and compliance.

- Teaming with the Regional Center: The Screening, Consent, and Referral Process for CSWs and PHNs

  This 3hour interactive training will provide CSWs and SCSWs information about current legislation, revised policies and procedures related to Regional Center. Child Abuse and Prevention Treatment Act (CAPTA) and Individuals with Disabilities Education Act (IDEA) mandate requires children ages 0-36 months be developmentally screened for Regional Center services if allegations of child abuse or neglect are substantiated. The importance of teaming will be discussed as it relates to planning for and servicing dual agency consumers. DCFS policies addressing Regional Center, Developmental Milestones Checklist, Consent forms and the revised Referral form to Regional Center (DCFS 5004) will be discussed.

ATTACHMENT J

Overview of the DPH Health Care Program for Children in Foster Care (HCPCFC) Nurse Training Program

A six (6) week new nurse orientation is conducted by a DPH Nurse Instructor (NI) as indicated below. The goal is to prepare and evaluate the PHN's progress towards working independently on a caseload. Upon completion, the PHN is assigned a PHN preceptor in their assigned DCFS office for an additional six (6) weeks and is assigned to a CSW unit, which typically consists of 8-10 CSWs with approximately 100-150 cases.

Type of Training	Length	Curriculum Overview
Didactic Training at Headquarters	3 Weeks	Extensive review of the HCPCFC PHN roles and responsibilities, current program policies and procedures; home visits; documentation standards; psychotropic medications; Specialized Care Increment (SCI) F-Rate; PHN consultation; out-of-county placement; emergency joint response and referral process to the CSW; and the referral process to the Regional Center, Medical HUB and other DPH programs.
On-Site Training at the PHN's Assigned DCFS Office	3 Weeks	Hands-on training with the NI regarding updating the HEP with current physical and dental exam information, and immunization status; accessing the Immunization CAIR system to update and monitor immunization status for each client; and performing actual consultation with CSWs by making referrals and coordinating care with a variety of outside agencies including the Medical HUB, Regional Center, mental health service providers, and other medical specialists. The NI also provides the PHN with training on the home visit process and instruction on how to assess the child's health care needs. The PHN attends Team Decision Making (TDM) and MAT meetings with the NI and receives assistance and training on how to independently review and update cases for F-Rate assessment and psychotropic medication as per court orders.

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WILLIAM T FUJIOKA
Chief Executive Officer

October 9, 2013

To: Supervisor Mark Ridley-Thomas, Chairman
Supervisor Gloria Molina
Supervisor Zev Yaroslavsky
Supervisor Don Knabe
Supervisor Michael D. Antonovich

From: William T Fujioka
Chief Executive Officer Bcmp for

REPORT BACK ON BUDGETED UNFILLED POSTIONS (AGENDA OF JUNE 24, 2013, ITEM NO. 5-G)

On June 24, 2013, on motion of Supervisor Antonovich, the Board of Supervisors (Board) directed the Chief Executive Office (CEO) to: (1) **Conduct a review** every 90 days of vacant budgeted positions, to identify those positions that have been vacant for 90 days or more and the unspent appropriation that can return to the County's general fund; (2) **Report to the Board** in writing every 90 days with the amount of funds that can be returned to the general fund and transfer these funds in all mid-year budget adjustments; and (3) **Report to the Board** with a clarification of salary savings by department.

In response to conducting a review every 90 days to identify positions that have been vacant for 90 days or more, below is requested information followed by descriptions of each of the column headings.

FY 2013-14 Adopted Budget
Data as of September 11, 2013

Fund	(1) Authorized ("Budgeted") Positions	(2) Funded Positions	(3) Vacant Funded Positions	(4) Vacant IFT/ Revenue Offset Positions	(5) Net Vacancies Column 3 minus Column 4	(6) Net Vacancies - 90 or More Days Vacant
TOTAL GENERAL FUND	72,507.0	67,999.0	3,098.0	1,637.0	1,461.0	312.00
TOTAL ENTERPRISE FUNDS	20,631.0	18,340.0	367.0	0.0	367.0	57.00
TOTAL SPECIAL FUNDS/ SPECIAL DISTRICTS	10,170.0	9,744.0	1,142.0	850.0	292.0	174.00
GRAND TOTAL	103,308.0	96,083.0	4,607.0	2,487.0	2,120.0	543.00

(1) **Authorized ("Budgeted") Positions** - reflects the number of positions the department has authorization to hire, but not necessarily the funding to pay for all the positions.

(2) **Funded Positions** - represents the number of positions for which the department has funding and can fill.

(3) **Vacant Funded Positions** - reflects the number of funded positions that are vacant.

(4) **Vacant IFT (Intrafund Transfers)/Revenue Offset Positions** (e.g., grant funded positions) - represents positions that are vacant, but will not result in savings because there will be a corresponding reduction in IFT/revenue due to the vacancy.

(5) **Net Vacancies** - reflects funded vacancies less the Vacant IFT/Revenue Offset positions.

(6) **Net Vacancies – 90 or More Days Vacant** - represents net vacancies which have not been filled within the last 90 or more days. Please note that the hiring freeze was recently lifted from departments and, therefore, we anticipate this number to decrease over the next three to nine months.

We will continue to provide your Board with this information quarterly.

In response to reporting to the Board every 90 days with the amount of funds that can be returned to the general fund and transferred in all mid-year budget adjustments, our office must conduct a comprehensive analysis of each department's entire budget to determine if there are any associated net County cost savings. While departments may have savings due to higher than expected vacancies, they may need to utilize the

associated savings to fund unanticipated increases in other areas. Also, positions may be held vacant due to lower than anticipated general departmental revenue, not related to grant funded positions and therefore would not result in savings. We will report back to the Board at the end of December with the amount of funds that can be returned to the general fund once our office has completed its 5th month Budget Status Report (BSR).

In response to Item 3 above, please note that salary savings is an adjustment to each department's gross salaries to more accurately reflect actual salary expenditures. Gross salaries are calculated based on the top step salary of each budgeted position. Salary savings looks at actual employee salary expenditures and includes such factors as top step variance (the actual step the employee is on compared to top step), under hires (the employee is holding a lower payroll title than the budgeted position), vacancies, hiring delays, and attrition.

Historically, some departments may have requested to add positions using existing resources. This provided departments with greater hiring flexibility in utilizing a variety of positions based upon their changing operational needs without increasing their budget. The department, in turn, would agree to keep a certain number of positions vacant. However, this practice of adding positions using existing resources has caused confusion with departments throughout the years. Therefore, we are revisiting this practice to reduce its occurrence.

Due to the complexities and dynamic nature of staffing, it has been challenging to obtain accurate and timely staffing information. With the recent implementation of eHR Position Control we now have access to this information. Therefore, we are working with departments and your offices to refine our methodology and policy to simplify the position budgeting process.

WTF:SHK:SK
AS:alc

c: Executive Office, Board of Supervisors
County Counsel
Auditor-Controller

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WILLIAM T FUJIOKA
Chief Executive Officer

January 7, 2014

To: Supervisor Don Knabe, Chairman
Supervisor Gloria Molina
Supervisor Mark Ridley-Thomas
Supervisor Zev Yaroslavsky
Supervisor Michael D. Antonovich

From: William T Fujioka
Chief Executive Officer

EXTENSION ON REPORT BACK ON BUDGETED UNFILLED POSITIONS (AGENDA OF JUNE 24, 2013, ITEM NO. 5-G)

On June 24, 2013, on motion of Supervisor Antonovich, the Board of Supervisors (Board) directed the Chief Executive Office (CEO) to: (1) **Conduct a review** every 90 days of vacant budgeted positions to identify those positions that have been vacant for 90 days or more, and the unspent appropriation that can return to the County's general fund; (2) **Report to the Board** in writing every 90 days with the amount of funds that can be returned to the general fund and transfer these funds in all mid-year budget adjustments; and (3) **Report to the Board** with a clarification of salary savings by department.

On October 9, 2013, we responded to the items above and indicated we would report back at the end of December with the amount of funds that can be returned to the general fund once our office had completed its 5th month Budget Status Report (BSR). As our office is still finalizing the 5th month BSR, we are requesting an extension to mid-February. At that time, we will also provide an updated number of positions that have been vacant for 90 days or longer.

Please contact me if you have any questions or need additional information, or your staff may contact Sid Kikkawa at (213) 974-1133, or via email at skikkawa@ceo.lacounty.gov.

WTF:SHK:
SK:AS:alc
c: Executive Office, Board of Supervisors
County Counsel
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WILLIAM T FUJIOKA
Chief Executive Officer

February 12, 2014

To: Supervisor Don Knabe, Chairman
Supervisor Gloria Molina
Supervisor Mark Ridley-Thomas
Supervisor Zev Yaroslavsky
Supervisor Michael D. Antonovich

From: William T Fujioka
Chief Executive Officer

FINAL REPORT BACK ON BUDGETED UNFILLED POSITIONS (AGENDA OF JUNE 24, 2013, ITEM NO. 5-G)

On June 24, 2013, on motion of Supervisor Antonvich, the Board of Supervisors (Board) directed the Chief Executive Office (CEO) to: (1) **Conduct a review** every 90 days of vacant budgeted positions, to identify those positions that have been vacant for 90 days or more and the unspent appropriation that can return to the County's general fund; (2) **Report to the Board** in writing every 90 days with the amount of funds that can be returned to the general fund and transfer these funds in all mid-year budget adjustments; and (3) **Report to the Board** with a clarification of salary savings by department.

On October 9, 2013 and January 7, 2014, we responded to the items above and indicated we would report back with the amount of funds that can be returned to the general fund once our office had completed the 5th month Budget Status Report (BSR). In finalizing the BSR, we identified 420 net general fund positions that were vacant 90 or more days, which equated to an approximate $7.7 million salary variance. While departments realized these savings, they were generally offset by lower than anticipated departmental revenues and unanticipated increases in other areas. Therefore, we are not recommending any funds be returned to the general fund. Additionally, we are recommending that any future savings be returned to the general fund at the end of each fiscal year through our current BSR process. This will provide departments the flexibility to respond quickly to changing priorities and/or unforeseen circumstances.

Below is the corresponding vacancy information for the 5th month BSR.

FY 2013-14 Final Adopted Budget
Data as of November 30, 2013

Fund	(1) Authorized ("Budgeted") Positions	(2) Funded Positions	(3) Vacant Funded Positions	(4) Vacant IFT/ Revenue Offset Positions	(5) Net Vacancies (3)-(4)	(6) Net Vacancies - 90 or More Days Vacant
TOTAL GENERAL FUND	72,668.0	68,160.0	2,978.0	1,631.0	1,347.0	420.0
TOTAL ENTERPRISE FUNDS	20,824.0	18,533.0	383.0	0.0	383.0	0.0
TOTAL SPECIAL FUNDS/ SPECIAL DISTRICTS	10,186.0	9,760.0	1,162.0	858.0	304.0	169.0
GRAND TOTAL	103,678.0	96,453.0	4,523.0	2,489.0	2,034.0	589.00

We will continue to monitor departmental vacancies through our periodic BSR process. This completes our report back on budgeted unfilled positions. If you have any questions or need additional information, your staff may contact Sid Kikkawa at (213) 974-1133, or via email at skikkawa@ceo.lacounty.gov.

WTF:SHK:SK
AS:alc

c: Executive Office, Board of Supervisors
County Counsel
Auditor-Controller

County of Los Angeles
CHIEF EXECUTIVE OFFICE
Kenneth Hahn Hall of Administration
500 West Temple Street, Room 713, Los Angeles, California 90012
(213) 974-1101
http://ceo.lacounty.gov

WILLIAM T FUJIOKA
Chief Executive Officer

September 30, 2014

To: Supervisor Don Knabe, Chairman
Supervisor Gloria Molina
Supervisor Mark Ridley-Thomas
Supervisor Zev Yaroslavsky
Supervisor Michael D. Antonovich

From: William T Fujioka
Chief Executive Officer

GOLF REVENUE

On the June 24, 2013, motion by Supervisor Yaroslavsky (attached), the Board directed the Chief Executive Officer (CEO) to allocate $989,000 to the Department of Parks and Recreation on a one-time basis instead of ongoing in the Fiscal Year (FY) 2013-14 Budget. Your Board further instructed the CEO to revisit the need to allocate additional future funds during Supplemental Changes to the FY 2014-15 Budget.

Based on the latest golf revenue projection from the Department of Parks and Recreation, we are recommending $2,109,000 in one-time funding in the FY 2014-15 Supplemental Changes, as the result of the continued $989,000 shortfall in golf revenue and an additional shortfall of $1,120,000 related to litigation involving the current operator of the Whittier Narrows Golf Course.

If you have any questions, please call me or your staff may call David Wei at (213) 893-2534.

WTF:RLR
RG:DW:kd

Attachment

c: Executive Office, Board of Supervisors
County Counsel
Parks and Recreation

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AGN. NO. 5-C

MOTION BY SUPERVISOR YAROSLAVSKY

June 24, 2013

As part of the Fiscal Year (FY) 2013-2014 Recommended Budget, the Chief Executive Officer included $989,000 in new, ongoing Net County Cost for the Parks and Recreation Department to cover a shortfall in golf revenue. This amount is in addition to $2 million included in the FY 2012-2013 budget. The decline in revenue has resulted from several golf course operators not meeting their contractual rent obligations, as well as a decrease in rounds of play since the economic downturn.

With the economy showing early signs of improvement and the Department making significant progress in transitioning to new golf course operators, it is premature to allocate ongoing revenues to the Department for what may ultimately prove to be a short-term problem.

I, THEREFORE, MOVE that the Board of Supervisors direct the Chief Executive Officer to allocate the $989,000 to the Department of Parks and Recreation on a one-time basis instead of ongoing, and revisit the need to allocate additional future funds during Supplemental Changes to the FY 2014-15 Budget.

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	MOTION
MOLINA	
YAROSLAVSKY	
KNABE	
ANTONOVICH	
RIDLEY-THOMAS	